First Friends Preschool
Cell: 060 679 3548
Lilford Road, Hout Bay
e-mail: Firstfriendspreschoolhb@gmail.com

ENROLMENT FORM

Copy of Clinic Card and birth certificate to be attached

CHILD:

Surname: _____First Names: _____

Name of your child to be displayed on their locker/hook: _____

Date of Birth_____/_____/_____I.D. Number_____

MOTHER:

Surname: _____First Names: _____

Residential Address:_____Postal Code:_____

Phone numbers: Home:_____Work:_____Cell: _____

Occupation:_____Name of Company: _____

E-mail address:_____

FATHER:

Surname: _____First Names: _____

Residential Address:_____Postal Code:_____

Phone numbers: Home:_____Work:_____Cell: _____

Occupation:_____Name of Company: _____

E-mail address:_____

Child resides primarily with Parents, Mother, Father, Grandparents, Other (please state):_____

Home Language:_____Religion:_____No. of Children: _____

Position of child:_____Have any siblings attended First Friends? _____

EMERGENCY CONTACT

Name of person to contact in case of an emergency should we be unable to contact you:

1. Name:_____Telephone number:_____Relationship to child:_____

2. Name:_____Telephone number:_____Relationship to child:_____

Please ensure that you notify the teacher of any changes in the home circumstances, address and mostimportantly TELEPHONE NUMBERS

MEDICAL AND DEVELOPMENTAL HISTORY (please only complete relevant questions to your child's age or milestones)

FAMILY DOCTOR:_____ **TELEPHONE NUMBER:**_____

PAEDIATRICIAN:_____ **TELEPHONE NUMBER:**_____

1. Any medical history in the family, including your child (e.g.: Allergies, eyesight, hearing, chest, heart conditions,epilepsy, etc)

_____

_____

2. Allergies_____

Were there any problems before, during or after birth of child: _____

Type of birth:_____ Birth weight: _____

Describe any feeding difficulties: _____

Describe any teething difficulties: _____

Name of Dentist:_____ Contact number: _____

How often does your child visit the dentist? _____

Age of sitting:_____ crawling:_____ walking:_____

Is your child left or right-handed?_____ Can he/she do buttons?_____ Dress?_____

Has your child any physical difficulties in doing the above?_____

Hearing problems?_____ Sight problems?_____

Is your child sensitive to light?_____ Dark?_____ Noise? _____

Does your child need a comforter during the day? (specify)_____

At what age did your child talk?_____ Does your child use baby talk?_____

Does your child have a speech impediment?_____

Has advice been sought? (and with whom?)_____

Does your child develop excessively high temperatures/fevers?_____

Convulsions? (specify)_____

Has your child been hospitalised? (specify)

_____

Has your child ever had a serious accident? _____

Frequent colds? (give details) _____

Has your child attended any therapy? _____

CIRCLE the illness which your child has had:

Chicken pox	Diphtheria	Measles	Mumps	German measles	Scarlet Fever

Whooping cough	Bilharzia	Malaria	Rheumatic Fever	Hepatitis	Other: (specify)

Other:_____

Is your child on any form of medication? (specify) _____

Does your child have any toilet problems? _____

SLEEPING HABITS:

What time does your child go to bed at night? _____

What time does he/she wake up in the morning? _____

Does your child have a nap in the afternoon? _____

Bedwetting problems?_____Does your child wear night nappies? _____

Is your child dependent on a dummy, toy, thumb, comforter, other? _____

How would you say your child sleeps? (peacefully, restless, nightmares, sleep walker – specify)

_____

What is your child's attitude on waking? _____

INTERPERSONAL RELATIONSHIPS

How does your child interact with family members? _____

How does your child interact with friends? _____

Who does he/she play with frequently? (State ages) Brother:_____Sister: _____

Family/ friends etc. _____

Is your child dependent on adults for much attention? _____

Please specify personality characteristic you have observed: _____

Does your child have stories read to him/her?_____By whom? _____

Do you play music in the home?_____What types? _____

Does anyone in the family play a musical instrument? _____

Does your child show interest in music? _____

Does your child dance or sing? (with rhythm, spontaneously) _____

How many hours per week would you say your child watches TV and what programmes does he/she watch?

_____

Does your child have access to videos?___What type of videos? _____

How many hours per week would you say your child plays on the computer? _____

DISCIPLINE:

What disciplinary action is used with your child at home?

_____

How does your child react to instructions or correction?

_____

Has your child got any nervous habits? _____

Does your child have any fears? _____

Has your child got a low frustration tolerance? _____

Frequent temper tantrums?____How do you deal with this? _____

Does your child have any special habits or idiosyncrasies that we should know about in order to understandhim/her?

_____

Has your child attended another school i.e. Is your child at school presently? _____

Name of school _____

Is Mom able to spend much time with the child? _____

Is Dad able to spend much time with the child? _____

Any other information you think we should know? (e.g.: divorce, death, adoption – specify)

_____

Name of person/s collecting child:

_____

_____

Please be assured that this information remains confidential and remains in your child's file

Please do not hesitate to discuss any problem with the Teacher or Principal. NO problem concerning yourchild is too small or unimportant for us to help with.

Signature:_____Date: _____

Relationship to child: _____